STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING _____ B. WING _____	10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTER	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance on 10/14/22. The facility was found not to be in substantial compliance with 42 CFR §483 Subpart B. One facility reported incident ACTS 9375 was investigated and found to be in compliance. Highest S/S = E. Survey dates: October 11 - 14, 2022. Census: 90 Sample: 19	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		11/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/07/2022

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure the comprehensive person-centered care plan was implemented for one (1) of 19 residents sampled. R69's care plan was not implemented and the facility failed to monitor the efficacy of R69's pain management regimen. The deficient practice resulted in R69 experiencing unrelieved pain. R69 is at a potential risk for psycho-social harm. Findings Include: Cross reference to F697 Pain Management. R69 was admitted to the facility on 02/16/18 with diagnoses that included unspecified polyneuropathy, unspecified gout, and abrasion of lower back and pelvis.	F 656	1 R69's pain was re-assessed and care plan was updated by the Nursing Operations Manager (NOM). NOM in-serviced staff on R69's individualized plan of care and educated staff on the importance of the implementation of R69's plan of care to maintain the resident's highest practicable well-being. 2. Licensed Nurses completed a comprehensive pain assessment for all residents. NOM and Unit Manager (UM) re-evaluated the individual needs for pain management for all residents, updated the plan of care, in-serviced the staff, and audited the implementation of resident's pain care plan. NOM and UM educated staff on reviewing and implementing	

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F 656	Continued From page 2 Review of the resident's care plan documents R69 to have pain in her right leg and to be managed with pain medication as needed. The care plan further documents she will be comfortable with current pain regimen. "Tolerable pain level is 3." Interventions include "Administer pain medication as needed for moderate to severe pain ...Assist me to repositioning as needed to maintain proper body alignment for comfort ...Divert attention to interest of activities as tolerated. Encourage me to attend activities ...Monitor pain level daily during care and as needed. Report to Charge nurse when c/o [complains of] pain or s/s [signs and symptoms of pain] noted." On 10/11/22 at 10:11 AM observed R69 in her room sleeping. At 12:04 PM a second observation was done of R69 in her room with her lunch tray in front of her. R69 stated she is in pain and has cramps radiating from her feet to her legs. R69 reported she received routine Tylenol every day, but it is not helping and is experiencing pain all day and night. Inquired if resident spoke to nursing staff, R69 stated she did about two weeks ago. Further observations of R69 were made in her room on 10/11/22 at 01:39 PM, 10/12/22 at 08:59 AM and on 10/13/22 at 08:11 AM, 10:41 AM, 11:08 AM, and 12:17 PM verbalizing pain. On 10/12/22 at 08:59 AM Certified Nursing Assistant (CNA) 22 was in the room waiting to provide R69 with care when R69 verbalized pain to this surveyor and wanted medication. This surveyor directed R69's request to CNA22. Review of the physician's orders documented	F 656	resident's individualized plan of care if non-verbal or verbal signs of pain is observed during care. 3. NOM educated staff to review resident's care plan/kardex and implement resident's individualized plan of care. Staff were also educated on monitoring resident's pain level every shift during care, reporting both verbal and non-verbal signs of pain to the Licensed Nurse, administering pain medications as ordered, and evaluating the effectiveness of pain medication to ensure that the resident's pain is managed. 4. A PIP (Performance Improvement Plan) team will be formed to monitor the implementation of resident's plan of care for pain to ensure that pain is managed. Team members of this PIP will review the resident's electronic record for pain monitor documentation, pain assessments, pain medication administration in the eMAR, and progress note documentation for the effectiveness of pain regimen. Performance monitoring will be tracked and will be reported during the monthly QAPI committee meeting.	

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F 656	Continued From page 3 R69 was prescribed Gabapentin Capsule 300 milligrams (mg) give two capsules by mouth three times a day for Neuropathy, Tylenol Tablet 325 mg give two tablets by mouth three times a day for Pain Management for 14 days, and Tylenol Tablet give 650 mg by mouth every 4 hours as needed for mild pain "(pain level 1-3/10)". On 10/13/22 at 10:12 AM interview and concurrent review of R69's electronic medical record (EMR) was done with Director of Nursing (DON). DON explained if medication is not effective, nursing staff should attempt non-pharmacological approaches, and inform the doctor if both pharmacological and non-pharmacological approaches are not effective. DON confirmed R69 has a physician's order for as needed Tylenol for pain. DON also confirmed R69 did not receive Tylenol as needed for mild pain on 10/11/22, 10/12/22, and 10/13/22. Inquired with DON if nursing staff document the effectiveness of routine pain medication, DON stated they should and upon concurrent review of the nursing progress notes confirmed nursing staff did not document the effectiveness of pain medication for the dates reviewed, 10/11/22 and 10/12/22.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		11/4/22

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F 684	Continued From page 4 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide resident centered needed care and services for one (1) of 19 residents sampled, Resident (R)24. The facility did not follow the physicians order to treat diarrhea for R24. Findings Include: R24 was admitted to the facility on 07/16/21 with multiple diagnoses which includes, hypertiensive chronic kidney disease and Cauda Equina Syndrome, a rare disease affecting a bundle of nerves in the spine. Review of R24's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/22/22, R24's Brief Interview Mental Status (BIMS) scored her at a 15 (cognitively intact). On 10/11/22 at 12:25 PM interview with R24 was done, R24 reported having frequent loose stools, diarrhea, and her physician was to recommend medication but was never administered any medication to treat diarrhea. During a second observation and interview at 02:56 PM, R24 was observed to finish her lunch and stated she tries not to eat certain foods due to having loose stools multiple times a day. R24 was then observed to point to the cheesecake on her lunch tray, R24 stated she did not want to eat the cheesecake served because it contains cream. On 10/12/22 at 02:46 PM a record review was done which found physician's orders for diarrhea, Imodium A-D Tablet 2 milligrams (mg) every 3	F 684	1. On 10/31/2022, Licensed Nurse administered PRN (as needed) medication for loose bowel movement to R24. Staff were educated to continue to monitor and report when R24 has a loose bowel movement. Licensed Nurse was educated to continue to monitor and administer PRN medication for LBM as ordered by the Attending Physician and update the Physician as needed. 2. Licensed Nurses reviewed the bowel movement record and eMAR /bowel regimen (medications to manage bowel) to identify other residents having loose bowel movements that are not being treated as ordered by the Physician. 3. An alert in the electronic record was created to appear on the Licensed Nurse Clinical Dashboard when CNA documents a loose bowel movement. Licensed Nurses were educated to review the Clinical Dashboard every shift to identify residents having loose bowel movement in real time to ensure medications for loose bowel movement is administered as ordered by the Physician. 4. DON/ADON will audit for loose bowel movements and bowel regimen (medication management) monthly and will report during the QAPI committee meeting.	

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F 684	Continued From page 5 hours as needed for diarrhea ordered on 07/30/21 and loperamide HCl capsule 2 mg every 3 hours as needed for diarrhea for 14 days after each loose stool ordered on 10/10/22. A review of R24's output for October 2022, notes R24 had loose stools on 10/04/22, three times on 10/05/22, on 10/07/22, 10/08/22 and on 10/12/22. A review of the Medication Administration Record (MAR) for October 2022 could not find documentation that the physician ordered treatment for diarrhea was implemented. Interview and concurrent record review was done with Registered Nurse Manager (RNM)1 on 10/14/22 at 08:49 AM. RNM1 explained "loose" documented in the R24's output is diarrhea and confirmed R24 had diarrhea on 10/04/22, 10/05/22. 10/07/22, 10/08/22 and 10/12/22 and did not receive treatment. RNM1 confirmed R24 should have received either Imodium or loperamide on those days.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to evaluate the effectiveness of regularly scheduled pain medication for one of two residents sampled for pain management. As a result of this deficient	F 697	1. Licensed Nurse re-assessed R69□s pain, updated the Attending Physician, and obtained new orders for pain management. Resident was placed on the alert charting for close monitoring and	11/4/22

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F 697	Continued From page 6 practice, Resident (R)69 had unrelieved pain. Findings Include: Cross reference to F656, Develop/ implement comprehensive care plan. R69 was admitted to the facility on 02/16/18 with diagnoses that included unspecified polyneuropathy, unspecified gout, and abrasion of lower back and pelvis. Review of R69's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/28/22, R69's Brief Interview Mental Status (BIMS) scored her at a 15 (cognitively intact). Review of the physician's orders documented R69 was prescribed Gabapentin Capsule 300 milligrams (mg) give two capsules by mouth three times a day for Neuropathy, Tylenol Tablet 325 mg give two tablets by mouth three times a day for Pain Management for 14 days, and Tylenol Tablet give 650 mg by mouth every 4 hours as needed for mild pain "(pain level 1-3/10)". On 10/11/22 at 12:04 PM R69 was observed in her room with her lunch tray in front of her. R69 stated she is in pain and has cramps radiating from her feet to her legs. R69 reported she received routine Tylenol every day, but it is not helping and is experiencing pain all day and night. Inquired if resident spoke to nursing staff, R69 stated she did about two weeks ago. During another observation at 01:39 PM, R69 continued to state she was in pain and the medication staff give her is not working and would like a stronger medication to relieve her pain. R69 stated from a scale of 0 to 10 her pain is at a 5.	F 697	documentation of pain and the effectiveness of current pain regimen. 2. Licensed Nurses completed a comprehensive pain assessment for all residents to identify other residents who may have unmanaged pain. The Attending Physician was updated if pain is not managed with current regimen and the care plan was updated accordingly. Residents were placed on the alert charting for close monitoring and documentation of pain and the effectiveness of current pain regimen. 3. Director of Nursing (DON) and Assistant Director of Nursing (ADON) educated staff on the Alert Charting Policy. Staff were in-serviced on utilizing the Alert Charting Flowsheet which is the documentation used to communicate resident□s concerns that require monitoring and documentation. Policy indicates that new onset or ineffective pain management is to be added onto the Alert Charting Flowsheet; and Licensed Nurse is to document on pain and effectiveness of pain regimen every shift while awake until resolved. Pain assessment will be completed at the time of admission, quarterly, and as needed to identify and address pain concerns. 4. A PIP (Performance Improvement Plan) team will be formed to monitor pain management. Team members of this PIP will review the resident□s electronic record for pain monitor documentation, pain assessments, pain medication	

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F 697	Continued From page 7 On 10/12/22 at 08:59 AM observed R69 in bed, finished with her breakfast. Certified Nursing Assistant (CNA) 22 was in the room waiting to provide R69 with care. R69 informed this surveyor she has pain on her left side and wanted medication. This surveyor directed R69's request to CNA22. On 10/13/22 at 08:11 AM observed R69 in bed, R69 stated she has muscle pain and needs a strong pain-relieving medication. R69 stated nursing staff keeps giving her Tylenol and Gabapentin but they are not relieving her pain. During a second observation at 10:41 AM, R69 was lying in bed with her eyes closed. R69 stated she received one of her pain medications, but her pain is still bothering her. Inquired if staff ask her if she is experiencing pain when providing care or comes back and checks if her pain has been relieved after taking pain medication, R69 stated staff do not ask her or come back and ask if the pain medication is working. During a third observation at 11:08 AM, R69 was in bed with her eyes closed and stated she continues to have pain in her leg and the pain is starting to "squeeze" the top of her right leg. During a fourth observation at 12:17 PM, R69 stated "the pain seems to be getting worse and the medication did not work. Climbing up to the thigh, they have to find me a stronger one." R69 stated from a scale of 0 to 10 her pain is at a 5. On 10/13/22 at 10:12 AM interview and concurrent review of R69's electronic medical record (EMR) was done with Director of Nursing (DON) and Registered Nurse Manager (RNM) 1. RNM1 stated R69 can verbalize her needs, has pain on her right leg and receives routine	F 697	administration in the eMAR, and progress note documentation.	

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F 697	Continued From page 8 medication. DON further stated if medication is not effective, nursing staff should attempt non-pharmacological approaches, and inform the doctor if both pharmacological and non-pharmacological approaches are not effective. Concurrent review of R69's EMR, DON confirmed R69 has a physician's order of as needed Tylenol for pain. DON confirmed R69 did not receive Tylenol as needed for mild pain on 10/11/22, 10/12/22, and 10/13/22. Inquired with DON if nursing staff document the effectiveness of routine pain medication, DON stated they should and upon concurrent review of the nursing progress notes confirmed nursing staff did not document the effectiveness of pain medication for the dates reviewed, 10/11/22 and 10/12/22.	F 697		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		11/17/22

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F 803	Continued From page 9 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure one (1) of 19 residents sampled, Resident (R)24 who were served food according to preference. Findings Include: R24 was admitted to the facility on 07/16/21. Review of R24's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/22/22, R24's Brief Interview Mental Status (BIMS) scored her at a 15 (cognitively intact). Review of R24's food allergies documented in R24's Electronic Medical Record (EMR) includes Basil and Broccoli. On 10/11/22 at 12:33 PM observation and interview with R24 was done during lunch. R24 stated the facility gives her the menu weekly and she can mark off her preferences, however, on the bottom of the menu she requests for a tuna sandwich and raisins every day just in case she doesn't like the food or is served with food she is allergic to. R24 stated the facility does not always follow her preference, "If I don't order a toss salad, don't give me a toss salad." R24 further stated she received brown rice for lunch although she requested not to have brown rice. Observed on R24's lunch plate brown rice and on R24's	F 803	1. R24□s menu was reviewed immediately by the Certified Dietary Manager (CDM). Menu alerts were created in PCC to trigger notices for Dietary staff to review documentation during meal prep and delivery. CDM re-assessed menu options for R24. CDM in-serviced staff on R24□s individualized menu and educated staff on the importance of accuracy for meal preparations and resident options. 2. CDM completed a comprehensive menu assessment for all residents. CDM and Chef NOM re-evaluated the individual needs for preferences and options for all residents, updated reviewed all preference requests for all residents, in-serviced the staff, and audited the tray lines for accuracy and auditing. CDM and Chef continued to provide dietary surveys to residents for continued feedback and implement methods to improve food service delivery. 3. CDM and team members performed daily tray audits on rotating floors and meal times. Staff were re-educated to review resident□s individualized menu and preferences. Staff were also	

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F 803	Continued From page 10 meal ticket under dislikes "brown rice". R24 provided a copy of the menu she gives to staff weekly that includes her preferences marked off. For lunch on 10/11/22, R24 crossed out with a black marker "brown" for "brown rice". On the bottom of the menu, R24, wrote and requested raisins and tuna sandwich every day, to have two packets of salad dressing, to not be served food that was cooked with broccoli, fresh thyme, cabbage, and zucchini and "Please don't serve or substitute crossed out items." On 10/13/22 at 12:08 PM during an interview with R24, R24 stated last night she received brown rice again during dinner. Review of the R24's weekly menu documents "brown" crossed out with a black marker for the menu item "brown rice" on the 10/12/22 dinner menu. On 10/13/22 at 08:21 AM interview with Certified Dietary Manager (CDM) was done. Inquired with CDM what the facility's process is to ensure residents' food preferences are accommodated, CDM stated staff go over the menu and ask residents what their preferences are and will also provide a weekly menu to the residents. The residents will cross out the items they do not want and submit it back to staff. On 10/13/22 at 02:02 PM a second interview and concurrent review of R24's preferences were done with CDM. Inquired what starches are provided daily at the facility, CDM stated white rice and brown rice is always provided and depending on the menu there is usually mashed potatoes. Concurrent review of R24's meal ticket on 10/11/22 and R24's weekly menu for the week of 10/10/22 to 10/16/22 provided to dietary staff, CDM confirmed R24 should have not received	F 803	educated on monitoring resident□s likes and dislikes during meal observations in dining rooms. For residents who choose to eat in their rooms, staff are educated to get feedback from residents and clinical staff on menu items that were not consumed and the reasons why they were not consumed. 4. CDM or designee will develop and implement meal preference and observation reports that will be monitored and will document the outcomes. Performance monitoring will be reported monthly to the QAPI committee. Results of improvements will be presented to the Resident Council.	

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	125013	A. BUILDING _____ B. WING _____	10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTER	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

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F 803	Continued From page 11 brown rice and "it should have been corrected and ...sent back for us to correct."	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		11/4/22

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F 880	Continued From page 12 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, review of the facility's policy and procedures, and interview with staff members, the facility failed to ensure a contractor, injecting COVID-19 boosters at the facility, demonstrate proper hand hygiene between glove changes while vaccinating the residents. This deficient practice may increase	F 880	1. ADON immediately provided education to the contractor on facility□s policy on hand hygiene to prevent the spread of infection. Contractor was observed to perform proper hand hygiene following the provided education.	

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F 880	Continued From page 13 the spread of infections and has the potential to affect the residents who are receiving vaccinations in the facility. Findings Include: On 10/13/22 at 10:38 PM observation and interview with Contractor (C)1 and Health Information Clerk (HIC)4 was done. Observed C1 and HIC4 in Resident (R)17's room as she expressed that she did not want to get the COVID-19 booster. C1 stated he is at the facility to administer COVID-19 boosters to facility staff members and residents. HIC4 stated he is assisting C1 to ensure C1 vaccinate residents who are eligible and consented to the booster. On 10/13/22 at 11:07 AM, during a second observation, observed C1 doff (take off) and don (put on) gloves without hand sanitizing and administering R82 with the booster injection, then continue to doff and don gloves without hand sanitizing between R36 and R35 after administering the COVID-19 injection. Inquired with C1 if he has been hand sanitizing between residents and glove use which C1 confirmed he did not and stated that he did not need to because wearing new gloves was sufficient. On 10/14/22 at 10:14 AM interview with Infection Preventionist (IP) and Director of Nursing (DON) was done. Inquired with IP and DON how the facility ensures visitors or contractors are washing their hands or hand sanitizing while at the facility, IP and DON stated during rounds staff are asked to remind visitors to wash their hands or hand sanitize. Staff are reminded if they see something is wrong, even with contractors or transporters, the facility is responsible for it. IP and DON	F 880	2. ADON educated other contractors who were at the facility regarding facility□s infection control practices such as hand hygiene and proper PPE (personal protective equipment) use. 3. In-serviced staff to educate and correct other contracted staff and/or visitors on facility□s infection control practices such as hand hygiene, and proper PPE use to prevent the spread of infection. 4. ADON/IP will audit for proper hand hygiene and PPE use by all staff including contracted staff monthly and will report during the monthly QAPI committee meeting.	

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F 880	Continued From page 14 confirmed C1 should have been hand sanitizing between residents and glove use. HIC4, who assisted C1 should have known and reminded C1. Review of the facility's policy and procedure (P&P) "Infection Control: HAND HYGIENE" revised on 07/20/22 documents "All staff in the facility are responsible for following hand hygiene policies and procedures including but not limited to Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Nursing Assistants, Physicians, Physician Assistants, Rehabilitation Therapists, External Consultants, Environmental Services, Dietary Services, paramedics, students and volunteers." The P&P further documents "When to perform hand hygiene: ...Before and after performing and resident care procedure...After touching a resident or their immediate environment...After removing PPE [Personal Protective Equipment] (e.g. [for example] gloves, gown, facemask)...	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of Product Safety Data Sheet, the facility failed to perform preventive maintenance on three Biohazard Response Spill Kits, Peroxide Multi Surface Cleaner and Disinfectant bottles located in hallway cabinets on the nursing units. As a result of this deficiency, the facility put the	F 921	1. The Maintenance Manger removed the three (3) Biohazard Response Kits, Peroxide Multi-surface Cleaner and Disinfectant bottles from their respective locations and properly disposed the containers. The CFO/COO and Maintenance Manager completed a	11/17/22

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F 921	Continued From page 15 residents, staff, visitors at risk for exposure to hazardous solutions. Findings include: During observations of the three Biohazard Response Spill Kits on 10/13/22 at 01:00 PM, it was noted that the Peroxide Multi Surface Cleaner and Disinfectant bottles appeared wilted with spillage of yellow substances. The Spill kits contained labels which said Updated 5/26/17 and Updated 2/2/21. During staff interview on 10/13/22 at 01:20 PM, the Maintenance Manager (Maint Mgr) stated that they have not used and/or done preventive maintenance on any of the kits since it was installed. The labels on the kits showed when it was last checked; 5/26/17 and 2/2/21. Review of the Product Safety Data Sheet for Peroxide Multi Surface Cleaner and Disinfectant read as follows: Hazards Identification, GHS Classification, Acute toxicity (oral) Category 4, Acute toxicity (Inhalation) Category 3, Acute toxicity (Dermal) Category 4, Skin corrosion Category 1A, Serious eye damage Category 1, Skin sensitization Category 1. Storage, store in a well-ventilated place, keep container tightly closed, store locked up. Hazardous combustion products, decomposition products may include the following materials: Carbon oxides, Sulfur oxides. Accidental release measures, ensure adequate ventilation, keep people away from and upwind of spill/leak, avoid inhalation, ingestion and contact with skin and eyes.	F 921	review of the facility to confirm that no other products were available in storage areas. Maintenance logs were reviewed on 10/13/2022 and updated to confirm the SDS manuals are up to date with the current products in the facility. 2. The Maintenance Manager re-educated the maintenance staff to continue to update the SDS sheets quarterly to confirm the products are in use as well as those items that are no longer in use. Additionally, confirming the existing products expiration dates are monitored, documented and/or disposed of properly. 3. Maintenance staff will document SDS sheets and inventory are up to date, in use and reporting items close to expiration or discarding those that have expired in the SDS log book. 4. The Maintenance Manager or designee will monitor and document in the logbook on a quarterly basis. Semi-annual training on active SDS inventory, storage, use, expirations and handling will be provided by Maintenance Manager or designee.	